# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
# (MEDICAID)

## PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

**Drug Requested:** **Kevzara®** (sarilumab) **Injection (Non-Preferred)**

**DRUG INFORMATION:** Complete information below or authorization will be delayed. Attach **all** medical documentation with lab values with this request form.

**Drug Form/Strength/Month:** _____

**Dosing Schedule:** _____ **Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Recommended Dose:**

**200 mg once every two weeks; Pre-Filled syringe single-dose use, 150mg/1.14mL or 200 mg/1.4mL solution**

**CLINICAL CRITERIA:** Complete below **ALL** lines for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are **NOT** checked.

- **Prescriber is a Rheumatologist**
- Diagnosis of moderate- to-severe active rheumatoid arthritis for adult patients

❑ Trial and failure of **at least ONE (1) DMARD (check each tried):**

| | | |
|---|---|---|
| ❑ methotrexate | ❑ azathioprine | ❑ hydroxychloroquine |
| ❑ sulfasalazine | ❑ leflunomide | ❑ auranofin |
| ❑ Other: _____ | | |

**AND**

❑ Tried and failed **ONE (1)** of the **PREFERRED** biologics below:

| | |
|---|---|
| ❑ Humira® | ❑ Enbrel® |

**Medication being provided by** (check applicable box below)**:**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**: **PropriumRx**

**(Continued on next page; Signature page MUST be attached to this request.)**

**(Signature page MUST be included with request form.)**

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***REVISED/UPDATED:** ~~10/31/2018;~~ **11/18/2018**;